

**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION****PART I: GENERAL INFORMATION**

Requestor's Name and Address:

MFDR Tracking #: M4-07-1719-01

HARRIS METHODIST HOSPITAL  
3255 W PIONEER PKWY  
ARLINGTON TX 76013

Respondent Name and Box #:

ZURICH AMERICAN INSURANCE CO.  
Rep Box # 19

**PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION**

Requestor's Position Summary: "...Few think that Medicare's reimbursement is Fair and Reasonable, as indicated by the commission's implementation of 140% of Medicare rates for physicians and 213.3% of Medicare rates for free standing surgical centers. The Medicare APC rate for this service is \$1704.59 times 140% is \$2376.43. We only received \$1352.12 in payment for this service-seriously below even the APC rate alone. We request the carrier to pay 140% of the APC rate."

Principal Documentation:

1. DWC 60 Package
2. Total Amount Sought - \$1034.31
3. Hospital Bill
4. EOBs
5. Medical Records

**PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION**

Respondent's Position Summary: "The billing in dispute has been paid at a fair and reasonable rate in accordance with TWCC guidelines, policies and rules, and the Texas Labor Code. Carrier has determined that \$1,314.12 represents an amount greater than or equal to the fair and reasonable reimbursement for this service. The provider must therefore prove that the reimbursement received is not fair and reasonable."

Principal Documentation:

1. DWC 60 Package

**PART IV: SUMMARY OF FINDINGS**

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
4/3/2006	42, 97, 226, 790, W1	Outpatient Surgery	\$1034.31	\$0.00
<b>Total /Due:</b>				\$0.00

**PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION**

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:

- 42-Charges exceed our fee schedule or maximum allowance amount.
- 97-Payment is included in the allowance for another service/procedure.

- 226-Included in global charge.
  - 790-This charge was reduced in accordance to the Texas Medical Fee Guideline.
  - W1-Workers Compensation State Fee Schedule adjustment. Reviewed by Medical Specialty Services –reconsideration denied.
2. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that “reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers’ Compensation Act, §413.011”...
  3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
  4. Division rule at 28 TAC §133.307(e)(2)(A), effective January 1, 2003, 27 TexReg 12282; and applicable to disputes filed on or after January 1, 2003 requires that the request shall include “a copy of all medical bill(s) as originally submitted to the carrier for reconsideration in accordance with §133.304.” This request for medical fee dispute resolution was received by the Division on November 9, 2006. Review of the documentation submitted by the requestor finds that the requestor has not submitted a copy of the original bill. Therefore, the requestor has failed to complete the required sections of the request in the form, format, and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(e)(2)(A).
  5. Division rule at 28 TAC §133.307(e)(2)(C), effective January 1, 2003, 27 TexReg 12282; and applicable to disputes filed on or after January 1, 2003 requires that the request shall include “a table listing the specific disputed health care and charges in the form, format and manner prescribed by the commission”. Review of the documentation submitted by the requestor finds that the requestor has indicated that the amount billed for the services in dispute is the total for all services charged on the hospital bill; however the documentation does not support that all of the services in dispute were rendered on the date of service listed on the requestor’s *Table of Disputed Services*. The requestor listed the disputed date of service as 4/3/06 on the *Table*; the total charges on the bill were for date of service 3/31/06, 4/1/06 and 4/3/06. Therefore, the requestor has failed to complete the required sections of the request in the form, format, and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(e)(2)(C).
  6. Division rule at 28 TAC §133.307(g)(3)(C), effective January 1, 2003, 27 TexReg 12282; and applicable to disputes filed on or after January 1, 2003 requires the requestor to send additional documentation relevant to the fee dispute including “a statement of the disputed issue(s) that shall include: (i) a description of the healthcare for which payment is in dispute, (ii) the requestor’s reasoning for why the disputed fees should be paid or refunded, (iii) how the Texas Labor Code and commission [now the Division] rules, and fee guidelines, impact the disputed fee issues, and (iv) how the submitted documentation supports the requestor position for each disputed fee issue. Review of the submitted documentation finds that the requestor did not discuss or explain how the Texas Labor Code and Division rules impact the disputed fee issues, or how the submitted documentation supports the requestor’s position for each disputed fee issue. The Division concludes that requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(C).
  7. Division Rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §133.1 of this title (relating to Definitions) and §134.1 of this title (relating to Use of the Fee Guidelines)”. The requestor asserts in the position statement that “Few think that Medicare’s reimbursement is Fair and Reasonable, as indicated by the commission’s implementation of 140% of Medicare rates for physicians and 213.3% of Medicare rates for free standing surgical centers. The Medicare APC rate for this service is \$1704.59 times 140% is \$2376.43. We only received \$1352.12 in payment for this service-seriously below even the APC rate alone. We request the carrier to pay 140% of the APC rate...” The requestor did not list which APC was used in their position statement to determine the allowance. Furthermore, the requestor did not discuss or explain how it determined that the 140% Medicare rate would yield a fair and reasonable reimbursement. Nor did the requestor submit evidence, such as redacted EOBs showing typical carrier payments, nationally recognized published studies, Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments, to support the proposed methodology. Nor has the requestor discussed how the proposed methodology would be consistent with the criteria of Labor Code §413.011, or would ensure similar reimbursement to similar procedures provided in similar circumstances. Review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that the payment amount sought is a fair and reasonable rate of reimbursement in accordance with 28 TAC §134.1. The request for additional reimbursement is not supported.
  8. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented

by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(e)(2)(A), §133.307(e)(2)(C), §133.307(g)(3)(C) and §133.307(g)(3)(D). Therefore, the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

#### **PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311  
28 Texas Administrative Code §133.307, §134.1, §133.1, §133.304  
Texas Government Code, Chapter 2001, Subchapter G

#### **PART VII: DIVISION DECISION AND/OR ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

#### **DECISION:**

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

12/7/09  
\_\_\_\_\_  
Date

#### **PART VIII: YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744.

**Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**